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AUTHOR Bauch, Jerold P.
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ABSTRACT

More babies of very young mothers (under age 16) die, are medically at risk, and have developmental and educational difficulties than children of older, but still relatively young mothers. Because of the etiology of adolescent pregnancy, the young mother is unlikely to seek comprehensive prenatal care at the first realization of pregnancy. In addition, young mothers seldom have any educational preparation for childbearing and parenthood, since many schools do not offer courses in this area. However, preparation for parenthood and comprehensive prenatal care can prevent most of the serious risk factors in adolescent childbearing. (Author/JA)

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George Peabody College for Teachers
VANDERBILT UNIVERSITY
NASHVILLE, TENNESSEE 37203
TELEPHONE (615) 322-7311

Box 81, Peabody College • Direct phone 327-8084

Betty Phillips Center for Parenthood Education

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THE EFFECTS OF EARLY CHILDBEARING - A SAMPLER OF FINDINGS WITH IMPLICATIONS

Presented to the
Seminar on Adolescent Childbearing and Parenthood
of the
National Association of State Boards of Education

April 30, 1981 Washington, D.C.

Jerold P. Bauch, Director
The Betty Phillips Center for Parenthood Education
Peabody College of Vanderbilt University
Nashville, Tennessee 37203

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THE EFFECTS OF EARLY CHILDBEARING -

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Introduction

There is a solid and extensive literature documenting the increased medical risk factors for babies of very young mothers. This literature is especially alarming in light of the fact that these risk factors have been well known for a long time and continue to be present in 1981. The risk factors are generally studied in populations of young parents who have not received systematic educational and medical preparation for the birth and care of their children.

It is the purpose of this paper to remind us of some of these serious risk factors, report on some promising new findings, and suggest ways to further ameliorate the significant problems of early childbearing. The literature cited will be representative but not exhaustive because of the limitations of time and space.

Medical risk factors

Babies born to mothers under age 16 are twice as likely to be premature or of low-birth-weight compared to babies born to mothers aged 20-24. The risk of prematurity and low-birth-weight is almost 40% higher for babies born to all teenagers (NCHS, 1978). Low-birth-weight is a significant problem because of its strong association with infant mortality and a variety of physical and neurological impairments.

Mental retardation, physical handicaps, and a variety of other birth defects are all present in higher proportions among the children born to teenage parents than among children of older parents. Most of these risk factors have both immediate and long-range effects on the child. Failure to

thrive and infant morbidity are both prevalent as a result of adolescent pregnancy.

Developmental risks

Babies born to very young parents are subject to a wider variety and increased frequency of developmental problems as well. They are less likely to be in stable, predictible family surroundings, and may be subjected to more medical intervention. They are parented by biological parents who often lack the skill, maturity and commitment needed to provide an optimal developmental environment. Many are cared for by other adults, especially grandparents, who may be less motivated, have less current knowledge, and feel resentment toward the baby.

These problems manifest themselves in social maladaptations, learning difficulties, and resistance to education. Children born to very young parents are highly represented in categories of developmentally delayed and learning impaired children, discipline problems, and underachievers (Kawi & Pasamanick, 1973; Sameroff & Chandler, 1975). Because these problems are present as the children enter and progress through school, they become important elements in a trajectory which is likely to produce the very same inappropriate behaviors and attitudes which led to their untimely birth (Anastasiow, 1977).

In short, more babies of very young parents die, are medically at-risk, and have developmental and educational difficulties than the general population. It must be noted, however, that the literature generated on the babies of very young mothers is most often generated from young mothers who have not had comprehensive educational and prenatal preparation for their parenthood.

Glimmers of promise

Because of the etiology of adolescent pregnancy, the young mother is quite unlikely to seek out comprehensive prenatal care at the first realization of the pregnancy. Large numbers wait until the third trimester before seeking medical attention and advice. In 1978 approximately 200,000 mothers in the United States who delivered before age 19 received no prenatal care during the critical first trimester of pregnancy (NCHS, 1978). These young parents have seldom had any educational preparation for childbearing and parenthood, since many schools have no offerings at all in this area. Those school systems with courses in "family life" or "education for parenthood" almost always provide these courses as electives, and seldom do more than 20% of the graduating class list such courses on their transcripts (TAPPA Reporter, January, 1978).

At this point, I wish to report two encouraging indications that things might be looking up for pregnant adolescents and their babies. First, there appears to be an increase in the availability and utilization of comprehensive prenatal care services. Between 1974 and 1978, the percentage of very young parents receiving no prenatal care whatsoever dropped from 25% down to 20%. In 1974 about 70% did not start prenatal care during their first trimester; by 1978 there was a 6-10% increase in beginning prenatal care very early in the pregnancy (Alan Guttmacher Institute, 1981). These small percentage gains, through not dramatic, are important in that they show improvement in a tragic set of circumstances.

Much is claimed for comprehensive prenatal care in the prevention of birth defects and the reduction of the risk factors among children born to

very young parents. One recent study has demonstrated that these claims are valid. Joe McLaughlin and his associates studied 317 mothers ranging in age from 13 to 39. All of these subjects were actively involved in a model comprehensive prenatal care program at Nashville's General Hospital. While it might have been expected that the younger first-time mothers might have less positive attitudes toward their babies, lowered perceptions of the capabilities of the babies, and that the babies themselves might exhibit some of the developmental delays and risk factors mentioned above, there were virtually no age-related differences. The researchers concluded: "It seems likely that the combination of selection factors for the Comprehensive Child Care Project and the extensive treatment involved in the project may have overcome the negative factors frequently associated with adolescent pregnancy" (McLaughlin, et al., 1979, p. 72).

In the 1981 update of 11 Million Teenagers, the Guttmacher Institute has also recognized the improved situation of prenatal care: "Improved prenatal care has reduced prematurity and low-birth-weight among all age groups..." (Alan Guttmacher Institute, 1981, p. 29). The continued high rates of low-birth-weight black babies appears to be related to their mothers' low socio-economic status and reduced access to social services, including prenatal care, rather than to other racial/ethnic factors. The Guttmacher Institute concludes that "...timely and high-quality prenatal care can do much to prevent the serious health consequences to mother and infant of adolescent childbearing" (1981, p. 70).

My interpretation (or speculation, if you will) of these findings and trends is that as you factor in good prenatal care, you factor out most of

the serious risk factors in adolescent childbearing. If this is true, then lots more babies are going to get a good, healthy start in life. But high quality prenatal care made more available is not the total answer. The assurance of a healthy start is a necessary but not sufficient condition for the quality and equality of life for these babies. They need parents who are motivated and knowledgable enough to respond to prenatal care and who are intelligent and skillful as parents for years to come.

I call for universal and comprehensive parenthood education, delivered well before the initiation of sexual activity and parenthood. This means a K-12 curriculum provided by the public, private and parochial schools to every student (see Caldwell and Pagan, 1979; Ziegler, 1979). And here again, there are some research hints that seem to support this notion.

Carolyn Brown from our Center has just completed a study of young people who took a parenthood education course in high school and some students who had no such course. After 5 years, the "trained" group had about the same number of children but they had delayed childbirth toward the end of the five-year period. The trained group scored better than the others in knowledge about child development and had somewhat better attitudes on independence-building and strictness. To confirm that quality parenting is neither automatic nor learned by trial-and-error, Brown found that no differences in knowledge were accounted for by having delivered a baby (Brown, 1981).

I am sure some of you have seen a poster or heard the phrase "I am the one who decides to see clouds or the sun." Well, on a very cloudy issue where there is little sun, I decide to see that sun. It remains for us all to push back the clouds, let sunlight into the life of every young person, and every baby. The most fundamental guarantee of the Constitution is that

of equality. Preparation for parenthood and universal, comprehensive prenatal care are clearly mechanisms for insuring equality for America's children of tomorrow. They deserve no less than our collective best to assure their future.

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